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ABSTRACT

An employment socialization project was developed to reduce the re-hospitalization of patients by assisting them in their re-entry into the world of work. The project was established by ex-psychiatric patients who took major responsibility for planning and implementing the project's activities with the clinic staff serving in an advisory capacity. Group meetings, directed by counselors, were held three times per week, with part of each meeting being devoted to employment related discussions and activities and part to recreation. Two successive programs were developed to increase the employability of chronic patients. During its three years of operation 250 patients have been referred to the project, and although no-statistical assessment is available many individuals have been employed for significant lengths of time. The essential benefits of the project appear to be: (1) it relieves clinicians of much of the load of providing supportive contact and serves to prevent or minimize breakdowns in patient's functioning; (2) it provides social-recreational experiences which can be used as an adjunct or alternative to psychotherapy; and (3) it offers opportunities for psychiatric patients to assume a formal role in helping others. (RSM)

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EMPLOYMENT-SOCIALIZATION PROJECT*

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Before describing in detail the employment-socialization project let me first discuss the community mental health setting in which this innovative social support program was conceived and developed.

Community mental health centers located in urban areas are confronted by a wide and complex array of service demands. In many instances there is a legal if not moral obligation to provide assistance or treatment to almost all area residents who apply. The sheer number of these applicants by itself can seriously tax a clinic's resources of personnel and direct service time. In addition, those applying for treatment usually vary a great deal in such characteristics as age, intelligence, motivation, and life style as well as in the nature, severity and chronicity of disordered behavior. In the catchment area served by the Gilpin House Mental Health Center, a decentralized, generic mental health team of Denver General Hospital, the residents are representative of perhaps the widest possible variety of variables. Among the patients served are a large number of boarding home residents who in many cases may have spent twenty or more years in state hospitals, alienated young adults who at the most are only marginally involved in school or work, drug users, alcoholics, and chronically unemployed welfare recipients. In this predominantly lower socio-economic population, emotional conflicts are often complicated by unemployment, immediate needs for financial assistance, and lack of supportive social contacts. Many of the area's residents are without family ties and are socially isolated, lacking either the skill, capacity, or the opportunity to form more than transitory relationships. Patients frequently drop out of treatment after only a few initial interviews and return again when the stresses they are experiencing become intolerable.

*The employment socialization project was founded by Charles Dewitt, Ph.D. former psychologist at Denver General Hospital and two ex-psychiatric patients, Clifford Schaffer and Hal Bernard.

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Any changes in habitual behavior patterns take place slowly and require a great deal of emotional support. Successful coping frequently breaks down before it can become firmly established because the clinician cannot continue to supply the support which is not available in the patient's environment.

The majority of the patients served by the clinic can be grouped into three general categories falling along a continuum corresponding to varying degrees of need for social support. At the end of the continuum requiring less social support are those patients who possess a number of adaptive characteristics. These are patients whose behavior is adequate in most respects except for limited problem areas and patients who have functioned well for most of their lives until meeting some stressful situation. Patients falling into this category constitute a small minority of the patients seen at Gilpin House. Another large patient segment consists of young adults who are intelligent and socially adept but have become depressed and alienated from productive relationships and activities. These young people have not been able to find a place in either the streight or hippie world.

At the other end of the continuum are those patients who are psychologically and socially crippled to an extreme degree. These patients have been institutionalized for a large proportion of their lives and have experienced little if any success in living independently. They are released from institutions to privately owned boarding homes which provide board and room but almost no social stimulation. They are typically passive or withdrawn; their affective response is mildly inappropriate; and their interpersonal skills are limited by behavior patterns which have become rigid by years of institutional living. When left to themselves these patients show little interest in their own well being and interact very little with people around them.

The patients occupying the middle of the continuum can be distinquished as socially inadequate rather than behaviorally crippled. In contrast to the behaviorally crippled patients, these patients have been hospitalized for acute disturbances, have spent less total time in institutions and possess at least minimal social and communication skills. They have usually experienced at least some intermittent success in satisfying their needs although many of them have been unable to consistently maintain employment or social relationships for any extended

periods of time. In contrast to the chronic, institutionalized patients, these individuals tend to be more interested in their surroundings and are motivated toward changing their situations. This group also includes a small number of remotivated, chronic patients who have regained interest in life as well as a minimal capacity for independent action.

A community mental health center serving a large, widely varied, high-risk population, is then faced with a dilemma. The large demand for direct service argues for the adoption of a brief, crisis-oriented approach. The extremely high incidence of chronically disordered behavior and social isolation, however, requires a tremendous expenditure of staff time and energy devoted to supportive efforts.

The Gilpin House mental health team, in attacking these problems directly, rejected several alternatives. Waiting lists, however protective of a clinic's limited resources, can easily be misconstrued as a polite form of rejection by patients who already feel isolated and ignored. Their needs for medication and crisis intervention are immediate and if not met may result in hospitalization or a strongly negative perception of the clinic which may preclude any further contact. Waiting lists, in fact, can be inefficient when dealing with individuals who may initially accept treatment only on a crisis basis before becoming seriously involved in any long range effort to change their behavior. A second unacceptable alternative is the unselective perscription of conventional group or individual psychotherapy. For many patients, the verbal encounters of psychotherapy may be perceived as irrelevant or too threatening; while for other patients, weekly clinic contacts may not provide enough support.

The Gilpin House staff has been developing a comprehensive system of treatment programs and supportive group activities designed to service a large patient load effectively while meeting specific patient needs and utilizing staff time and skills efficiently. A variety of treatment programs which include both group and individual psychotherapy have been organized around significant characteristics of the patient population such as age, chronicity, particular problem areas and capacity to deal with more than concrete circumstances. For example, the clinic has several young adult groups, alcoholism groups, drug abuse groups, a group of young married couples, and groups in which the problems of daily living are discussed. As the number and character of the patients

seeking treatment at the clinic changes groups may be disbanded or new groups may be organized.

Two of the supportive programs, the aftercare program and the employment-socialization project, were developed to provide activities which could be used either as an adjunct or as an alternative to psychotherapy. Patients, who after the initial intake or after any number of sessions are judged to have received maximum benefits from psychotherpy but who need continued support can be referred to an appropriate supportive program. Supportive programs when used as an adjunct to psychotherapy can indirectly increase the amount of contact a patient has with the clinic as well as provide the patient with an experience which differs from psychotherapy. Professional time is conserved through the extensive use of para professionals and volunteers to staff the supportive activities.

The aftercare program was developed as a supportive and remotivating service for chronic patients living in boarding homes whose marginal adjustment is maintained primarily through the use of drugs and supervised living arrangements. The most debilitated patients attend regular meetings held at their boarding homes by visiting nurses who attempt to stimulate conversation and interest in activities outside the residence. Many of these patients also attend a medication clinic on a regular basis where an attempt is made to interest them in the clinic's program of activities. The more mobile patients attend two weekly social hours held in a building near the clinic. Interpersonal skills and increased decision-making ability are encouraged during these social hours by giving patient committees the responsibility for social hour programs and projects such as decorations, invitations and refreshments for special parties. Visitors from community groups and agencies stimulate an interest in community activities, personal appearance, restoration of civil rights and hobbies. More highly motivated patients may participate in a travel group to learn to find their way around the city, or they may work in a privately-operated crafts shop. All of these groups are directed by para-professional aids or volunteer workers under the clinic's supervision. Many of the patients regularly attend more than one group and participate indefinitely. The multiple contacts by staff members and volunteers who direct these groups form a supportive network which appears to foster changes in behavior and often provides warning of impending breakdowns.

A second social support system, the employment socialization project was selected as the focus of this report because of its innovative aspects, its multiple functions, and its applicability as a support system throughout the entire range of the clinic's treatment programs.

The employment socialization project was originally established as a small, formally organized group by ex-psychiatric patients who had been treated at the clinic and who wished to extend assistance to other patients further behind on the path to recovery. These ex-patients became volunteer "counselors" and took major responsibility for planning and implementing the project's activities, with the clinic staff serving only in an advisory capacity. There were strong feelings among the orgainizers of the project that ex-patients might have a perspective and understanding different from that of professional care givers and that they could create an enjoyable, educative experience qualitatively different from psychotherapy. One form of support, for example, which cannot be adequately provided in outpatient psychotherpy is that of recreational activities which provide opportunities to socialize and make friends.

The organizers defined the purpose of the project as an experimental attempt to reduce the rate of re-hospitalization of patients by assisting them in their re-entry into the world of work and social relationships. Any patient referred by the clinic staff who genuinely wanted to change his situation was accepted into the project's activities if he needed social-recreational outlets or help in learning skills related to obtaining and holding employment. Most of the patient served by the project, however, function at a higher level than the typical boarding home patient and fall within the age range of thirty to sixty. These patients can be characterized as falling midway on the need for social support continuum.

The use of meeting rooms in a church located in the catchment area was obtained in order to further divorce the project from psychotherapy and group meetings directed by the "counselors" were scheduled for three evenings each week. A part of each meeting was devoted to employment-related discussions, while the remainder of the evening was given over to recreation. Unemployed patients attended discussions which provided concrete and personal help in learning how to go about finding employment openings, filling out applications, and interviewing for employment.

Patients who were regularly employed attended discussion groups in which they had the opportunity to talk about any problems which might arise at work.

Over the course of the the three years that the project has been in existence, new "counselors" have been recruited from the patients served by the project as the older counselors found paid employment or quit for reasons involving their psychiatric problems. The turnover in the "counselor" staff which introduced new personalities with different interests and capabilities as well as a large expansion of the clinic's services has brought about several changes in the project's functioning. In addition to contributing to the continuity from inpatient to outpatient care, the activities of the project have taken on these added dimensions:

1. Project activities afe used as an alternative form of treatment for patients who need only emotional support and social-recreational experiences. Clinicians usually maintain contact with the patient through the project's staff.

2. Project activities are used as an adjunct to psychotherapy to provide social-recreational experiences.

3. Project activities are used to extend care indefinately for patients who no longer need psychotherapy but who do need long-term, low intensity contact with a mental health clinic.

4. Project activities are used to evaluate the capabilities of vocational rehabilitation referrals and hold them in the psychiatric care system while their applications are being processed. Frequently the most realistic treatment program for disadvantaged patients is vocational re-training and supportive contact. Unfortunately many patients in this transient population do not return for subsequent appointments or cannot tolerate the inevitable delay between their first interview with a vocational rehabilitation counselor and the training program or job referral which may result after a number of appointments with the counselor. The patient's attendance at project activities , however, can provide an indication of whether the patient is interested in continuing his contact with the clinic and can serve as a supportive contact with the clinic while he is waiting for rehabilitation plans to crystalize.

Two successive programs to increase the employability of patients have been developed in a joint effort of the "counselors" and the

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clinic staff. The goal of the first program was to improve the job finding skills of those chronic patients whose participation in the aftercare activities indicated that they had some potential for employment. Several groups of boarding home patients participated in a series of group discussions in which they talked about their fear of returning to work, practiced filling out employment applications, and roll-played interviews with prospective employers on video tape. Only one or two of the approximately twenty patients who came to some or all of the sessions were able or motivated to find employment. Many of the patients, however, began to relate to each other more spontaneously and appropriately which suggested that the program had had some impact.

A second effort to work with these very chronic patients is currently showing more promising results. Instead of talking about or roll-playing employment situations, the patients are placed in various volunteer work positions in the general hospital shortly after joining the work therapy group. In weekly meetings the patients discuss real problems which they encounter at work as well as their supervisor's reports on their work habits. The volunteer counselors frequently act as co-leaders of the group with a student or a clinic staff member and also serve as a laison between the group and the work supervisors at the hospital. Almost half of the patients who have been placed at the hospital have now been satisfactorily working in a volunteer capacity from three to six months. The number of these limited successes is small, however, and a relatively large number of patients still come to only one or two meetings and drop out even before being placed at the hospital. Future plans involve moving as many of these patients as possible from volunteer jobs to paid imployment in the community as soon as appropriate placements can be arranged.

During the three years of operation more than two hundred and fifty patients have been referred to the employment socialization project. Even though about forty percent of the patients referred to the project never attend more than one meeting, the combined weekly attendence at the evening meetings has averaged between fifteen and twenty patients. Eight patients have been deeply involved as "counselors" in the planning and operation of the project and numerous others have been asked to help out from time to time. Only one of the five counselors to leave

the project has returned to an unproductive existence. Although there is no statistical assessment currently available of the adjustment of the patients who have been served by the project, there are many examples of patients who have become employed for significant lengths of time after long periods of unproductivity.

In summary, supportive services orgainized along the lines of the employment socialization project appear to have increased the clinic's capacity to effectively serve a high risk population, disadvantaged in the respect that the patients in this catchment area have few of the common social supports such as family, friends, or employment. The essential features of supportive services in this setting appear to be the following:

1. Supportive services relieve clinicians of much of the load of providing supportive contact and serve to prevent or minimize breakdowns in patients' functioning.

2. Supportive services provide social-recreational experiences which can be used as an adjunct or alternative to psychotherapy.

3. Organizations which provide supportive services can offer opportunities for psychiatric patients to assume a formal role in helping others.